Elements of effective nutrition education for adults with diabetes mellitus in resource-poor settings: A review

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How to cite this article:

This article is available at: www.hsag.co.za

ABSTRACT

This review article highlights the key factors that need consideration in planning an effective nutrition education programme for adults with type 2 diabetes mellitus in resource-poor settings.

Type 2 diabetes is increasing to epidemic levels globally. Low socio-economic status is associated with poorer health outcomes and a higher economic burden. Individuals with diabetes cite dietary adherence as the most difficult self-care area. Effective nutrition education achieves the desired goals and outcomes, which include appropriate change in dietary behaviour, improved glycaemic control, plasma lipid levels, blood pressure and body weight, as well as improved potential mediators (knowledge, skills and attitudes). Elements that contribute to a successful nutrition education programme include interventions tailored to the needs, abilities and socio-cultural context of the target group, the active involvement of the patient, a behaviour-focused approach based on appropriate theory, suitable delivery methods and individual/group approaches. Adequate contact time with an educator (> 10 hours), the educator’s competence, provision of social support and follow-up intervention are also crucial.

Effectively educating diabetic individuals from resource-poor settings in nutrition is a challenging task. It needs innovative and skilled educators who are sensitive to the unique needs of the target group and who use appropriate approaches to address these needs.

INTRODUCTION

The prevalence of diabetes is increasing globally to such high levels that it is being referred to as ‘an epidemic’ (Wang et al. 2005:174; Wild et al. 2004:1047). Diabetes is a complex disease associated with considerable morbidity, mortality and loss of quality of life (Narayan et al. 2000:78). Diabetes places a significant economic burden on health care systems and individuals suffering from the condition (Narayan et al. 2000:79; Ramachadrán et al. 2007:252). Groups with a low socio-economic status tend to bear the brunt of this burden, as they spend a higher proportion of the family’s income on diabetes care (Narayan et al. 2000:79; Ramachadrán et al. 2007:255). They have also been noted to be among those with poor long-term diabetic outcomes (Bell et al. 2001:128; Chin, Zhang & Merrell 1998:1091; Roper et al. 2001:1389) and poor glycaemic control (Levetan, Levitt & Bonnici 1997:368). It is therefore critical that special attention, as well as feasible and effective diabetes management strategies, be directed specifically at populations in resource-poor settings.

Patient education, also referred to as diabetes self-management education (DSME), is a cornerstone of treatment for diabetes (ADA 2007a:30). Diabetes education is the process of providing the diabetic with the knowledge, skills and motivation that are needed to perform self-care, manage crises and make the lifestyle changes required to successfully manage their condition (Clement 1995:18). An extensive body of literature exists that demonstrates that DSME significantly improves health outcomes (Asha, Pradeepa & Mohan 2004:101; Ellis et al. 2004:103; Norris, Engels & Narayan 2001:561; Norris et al. 2002:1159; Warsi et al. 2004:1647).

Medical nutrition therapy (MNT) is an integral component of diabetes treatment and self-management education (ADA 2007:30). MNT, both as an independent variable and in combination with other
components of DSME, has been shown to be effective in improving health outcomes (Pastors et al. 2002:69; Pastors et al. 2002:682). It can prevent or postpone the onset or slow the progression of costly complications of diabetes. In non-insulin dependent diabetes there is potential for cost savings through decreasing or discontinuing the use of oral hypoglycaemic agents when diet and exercise alone can provide the desired outcomes (Gagliardino & Etchegoyen 2001:1005; Hampton, Bodansky & Stickland 1998:166; PADA 1995:89). MNT has also been shown to produce similar outcomes to those of oral glucose medication alone (Franz et al. 2003:30).


Despite the established role of MNT in enhancing diabetes control, many individuals with diabetes are not benefiting from NE programmes. Some of the reasons for this include: culturally incompatible programmes (Anderson-Loftin et al. 2002:247; Brown et al. 2005:527), programmes that only target knowledge transfer and those that do not actively involve the patients (Clement 1995:1205; Knight, Doman & Bundy 2006:495). The problem may further be compounded by the fact that, when compared with other diabetes self-management areas, dietary self-management is noted to be the most difficult (Anderson-Loftin et al. 2002:247; Glasgow et al. 1997:558). This is particularly apparent among low-income groups (Cox et al. 2004:163).

Diabetic individuals from resource-poor settings are also faced with unique issues that may limit their ability to benefit from education programmes. They have a higher prevalence of low literacy, which poses a challenge to the appropriate understanding of diabetes and its management (Eakin et al. 2002:27). Language barriers may contribute to a lack of motivation to seek appropriate health care (Anderson-Loftin et al. 2005:556; Glazier et al. 2006:1675). Low income levels and limited access to transport hinder their access to continuous quality care (Cox et al. 2004:29; Eakin et al. 2002:18; Glazier et al. 2006:29). Cultural beliefs may also mitigate against taking on a greater role in self-care (Eakin et al. 2002:18; Glazier et al. 2006:29). Therefore, they may experience more barriers to self-managed care than their counterparts in higher socio-economic settings.

Given that educating patients to better manage their diabetes is a feasible strategy due to low technical complexity, low capital requirements and cultural adaptability (Narayan et al. 2006:175), effective NE programmes could be utilised to bring about the desired outcomes in diabetics. This, consequently, would reduce diabetes-related complications and the associated socio-economic burden, which is of particular concern in resource-poor settings.

To design effective nutrition education programmes for diabetic individuals from resource-poor settings, it is essential that the developers be knowledgeable about those characteristics that contribute to a successful programme. In this review we define a resource-poor setting as a geographical location with limited infrastructure (facilities and services) and a population with low income. Although several interventions have been implemented in resource-poor settings, there is a lack of consolidated data on the factors that specifically contribute to the effectiveness of nutrition education programmes. The main objective of this article was to review published reports on nutrition education interventions in diabetes care since 1995. The specific objectives were:

- to identify the elements that contribute to an effective nutrition education programme for adults with diabetes in resource-poor settings, and
- to provide guidance to health professionals intending to plan NE programmes for diabetic populations in resource-poor settings.

The methods for finding the selected material included the use of the databases Medline, PubMed and Cumulative Index to Nursing and Allied Health (CINAHL), which were searched for the terms effectiveness, nutrition education, dietary intervention, self-management education, type 2 diabetes, low-income, and resource limited/poor setting. Studies were included if they involved adult participants diagnosed with type 2 diabetes and dietary intervention, if the outcomes were reported and if the articles had been published between 1995 and the present date (November 2008). Only articles in English and those that used human participants were included. The samples were not restricted to any continent. Review articles that met the criteria were also included.

An effective nutrition education programme

An effective NE programme achieves the desired goals and outcomes that relate to an appropriate change in dietary behaviour (Contento, Randall & Basch 2002:12). An appropriate change in dietary behaviour is reflected in healthy food choices and eating habits (Contento et al. 2002:12; PADA 1996:1184). The primary outcome expected from this change is improved glycaemic control (ADA 2007b:48; Pastors et al. 2003:827). Other desirable outcomes include improved lipid profile, blood pressure and body weight (ADA 2007b:48; Pastors et al. 2003:827). Potential mediating factors, including knowledge, attitudes and skills related to diabetes and diet, are also expected to improve (Peyrot 1999:64-5).

Active involvement of the learner/patient

The responsibility for diabetes care lies primarily with the individual with diabetes (Anderson & Funnel 2000:597). To acquire the knowledge, skills and attitudes necessary for appropriate self-care behaviours, including diet, he/she needs to be actively involved in the learning and decision-making processes. The active involvement of the learner has been shown to be more effective in improving diabetes self-management outcomes than the didactic teaching approach (Elasy et al. 2001:125; Glazier et al. 2006:1687; Knight et al. 2006:498; Norris et al. 2001:583).


Behaviour-focused approach based on appropriate theories/models

Research indicates that the correlation between knowledge and behaviour change is low (Clement 1995:1205; Day 2000:73; Norris et al. 2001:580), and that education programmes that incorporate behaviour change strategies are more effective in changing behaviour (Brown 1999:52; Campbell et al. 1996:379; Clement 1995:18; Contento et al. 2002:12). Therefore, nutrition education programmes for individuals with diabetes must go beyond knowledge, and target dietary and other nutrition-related behaviours.

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No figures or tables present in the text.
The factors that should be targeted to help individuals change their dietary and other health behaviours include psychosocial factors that are antecedents of behaviour, such as personal factors (attitudes and beliefs), behavioural capabilities (knowledge and skills) and environmental factors that facilitate or impede change (Contanto et al. 1995:326). Peyrot and Rubin (2007:2434) have suggested targeting the following factors in diabetes interventions:

- Motivators (factors that predispose one to action, such as perceived need, perceived benefits of treatment, outcome expectancies, rewards/incentives and cues to action)
- Inhibitors/facilitators (barriers such as a lack of funds, skills and support or resources for action)
- Intentions (proximal cause of behaviour change, i.e. individuals must have an intention to change, be ready to change and have a goal towards which they can work)
- Triggers (events that shift a person from being predisposed to action into an action state). (Figure 1 shows a framework of these factors).


The most commonly used theories in diabetes education include the Health Belief Model (HBM), the Theory of Planned Behaviour (TPB), Socio-Cognitive Theory (SCT) and the Trans-Theoretical Model (TTM). The HBM (Rosenstock, Strecher & Becker 1988:15) emphasises perceived threat as a motivating force and perceived benefits (fewer barriers) as providing a preferred path to action. The HBM, as applied to dietary adherence for diabetes management, includes beliefs about personal susceptibility to the secondary complications of diabetes, the severity of diabetes and its complications, the belief that dietary adherence will render benefits in preventing the complications, the perception that barriers and other costs related to dietary adherence are not excessive, and that individuals have the ability to make the recommended dietary changes (Chapman et al. 1995:75).

The TTM (Prochaska & Velicer 1997:38-48) views behaviour change as a process in which the individual progresses through a series of six distinct stages of change. To successfully use this model, it is necessary to identify the participant’s stage and then match the offered education to that stage. Ruggiero (2000:13) has discussed the application of TTM in diabetes, providing guidelines for assessment and behaviour change interventions for diabetes care. The model was utilised in a randomised controlled trial to distinguish the diabetes-related characteristics of individuals at different stages of change towards healthier, low-fat diets (Vallis et al. 2003:1469). In this study, overweight individuals with type 2 diabetes identified to be in the action stages (action and maintenance) had healthier eating behaviours than those in the pre-action stages (pre-contemplation, contemplation and preparation) (Vallis et al. 2003:1472).

The SCT (Bandura 2001:52) describes learning as a reciprocal interaction between an individual’s cognitive processes, the environment and behaviour (reciprocal determinism). This is the basis for including interventions at the level of both the environment and the individual. The model has several constructs, but those commonly applied in diabetes include reinforcement (Miller et al. 2002:254), behaviour capability (knowledge and skills necessary to perform a behaviour) (Miller et al. 2002:254) and self-efficacy (confidence in one’s ability to successfully perform a specific behaviour) (Garret et al. 2005:321).

The TPB is an extension of the Theory of Reasoned Action (TRA) (McKenzie et al. 2005:152-153). The TRA states that an individual’s intention to perform a given behaviour is a function of his/her attitudes toward performing the behaviour and their normative beliefs about what relevant others think they should do, weighted by the motivation to comply with those others. Perceived behavioural control, the additional concept in PTB, asserts that behavioural intent and behaviour are also influenced by the degree of control people feel they have over circumstances, or in being able to perform a given behaviour. The more favourable the attitude and subjective norm with respect to a behaviour and the greater the perceived degree of control, the stronger the individual’s intentions to perform the behaviour (McKenzie et al. 2005:152-153). Chapman et al. (1995:25) applied the TPB theory to older diabetic adults. They found that the intention to consume certain high-fat foods was strongly related to subjective norms, attitudes towards dietary adherence and perceived control.

### Appropriate medium of delivery and group/individual settings

Education programmes could be delivered using a face-to-face approach, written material, the telephone and electronic methods. The face-to-face method is used most commonly (Ellis et al. 2004:103; Knight et al. 2006:486) and the one associated with better health outcomes in DSME programmes (Ellis et al. 2004:103; Warsi et al. 2004:1646), even among disadvantaged populations (Glazier et al. 2006:1687).

Individual and group approaches have both been used in diabetes patient education in almost equal frequencies (Elasy et al. 2001:124). However, very few studies have directly compared the effectiveness of group versus individual formats for delivering a specific intervention. Rickheim et al. (2002:272), in a randomised controlled trial comparing the effectiveness of the two approaches, observed that both approaches showed improvements in body weight, psychosocial adjustments, mental health and attitudes towards diabetes and glycaemic control, but with a slightly more marked reduction in HbA1c in the group setting. Another randomised controlled trial comparing group education versus individual consultations delivered as routine diabetes care in type 2 diabetes observed that, after two years, the group participants had better health outcomes. They had sustained their levels of HbA1c, while the levels of those in individual settings had worsened. The individuals in group setting also had increased HDL cholesterol levels and had reduced their body mass index (BMI) and triglyceride levels (Trento et al. 2001:999).

A systematic review of randomised controlled trials showed that group delivery was more effective for lifestyle programmes
(interventions focusing on diet and physical activity) (Norris et al. 2001:583). However, group versus individual delivery was found not to be a statistically significant predictor of glycaemic control in a meta-analysis by Norris et al. (2002:1164). Clement’s review of DSME (1995:1208) observed that small groups and one-on-one education might be equally effective in enhancing self-care behaviours and glycaemic control, and suggests that an optimum programme is one that uses both formats. Brown (1999:56-7) concluded that a combination of the two approaches achieved higher knowledge gains in diabetes self-management programmes and supported the use of small groups of ten participants or fewer.

A combination of the above-mentioned approaches could provide more benefits than those offered by either alone. Group processes encourage changes in beliefs and values as members share their knowledge, beliefs and skills and use the experience of others as a model (Garrett et al. 2005:322; Maldonato et al. 1995:61).

In a group setting, individuals can obtain emotional support from people with similar experiences (García & Suarez 1996:29; Van der Ven 2003:16). Group education is also cost effective and efficiently utilises scarce resources (Mensing & Norris 2003:16; Wilson 1997:32). One-on-one education allows better tailoring to each individual’s needs and better interaction based on non-verbal signals (Maldonato et al. 1995:61; Wilson 1997:70). It is useful in exploring long-term intrapersonal problems (Van der Ven 2003:88) or in initial education, when educational objectives need to be strictly selected, especially in the presence of severe emotional distress (Maldonato et al. 1995:61).

Wilson (1997:71) has suggested using telephone contacts to follow up on progress and to provide individual counselling after or in between group sessions as a way of combining the two methods. The latter is more feasible in resource-poor settings. A combination of the two approaches was utilised in a DSME pilot programme for low-income Spanish-speaking patients in which the majority of the sessions were dedicated to the group format. The study observed significant improvements in glycaemic control at three and six months (Rosal et al. 2005:331).

Tailored intervention

Education programmes must be matched to the needs and abilities of the patient (Clement 1995:1210; PADA 1996:1184; Fischer & Glasgow 2007:2746) if they are to be effective. Messages and materials that are customised to address the unique needs and concerns of specific patients have been shown to be effective in changing health-related behaviour (Clark 2002:183-4; Kreuter & Strecher 1996:103).

To design a targeted education programme, a needs assessment is recommended (Eakin et al. 2002:28; PADA 1996:1183-1184; Rosal et al. 2005:227). This exercise helps to provide a better understanding of the target group in terms of aspects such as knowledge, attitudes, barriers and facilitators to behaviour change, needs and preferences for diabetes education (PADA 1996:1183-4; Rosal et al. 2005:227).

Different methods can be used to conduct a needs assessment (McKenzie et al. 2005:72-83). However, the use of focus groups has been a major strategy in developing or adapting self-management interventions, especially in low-income and minority groups (Benavides-Vaello et al. 2004:238; Blanchard et al. 1999:919; Funnel et al. 2005:168). The informal nature of focus groups is conducive to identifying barriers to care, exploring health beliefs, identifying education needs and gathering information to improve intervention programmes (Benavides-Vaello et al. 2004:238). The synergy promoted by the group interaction produces ideas and statements that would not be generated with other types of methods. Respondents can qualify and clarify ideas and thus conveying more thoughtful and in-depth information (Betts, Baranowski & Hoer 1996:280; Blanchard et al. 1999:919).

Needs/abilities that need special consideration

Literacy levels

A high proportion of low-income populations have low literacy levels (Anderson-Loftin et al. 2002:248; Rosal et al. 2005:226), therefore the content of the education programme should be simple so as to increase comprehension and compliance (Anderson-Loftin et al. 2002:249; Brown 1999:231; Rosal et al. 2005:226; Ziemer et al. 2004:1719).

Strategies and educational materials that enhance understanding should be incorporated, e.g. the use of visual materials, action-oriented teaching, repetition of key concepts and skills, facilitation of frequent timely feedback (Rosal et al. 2005:226) and the practice of focusing on a few dietary concepts at a time (Anderson-Loftin et al. 2005:557). Other strategies include minimal reading activities, such as group discussions, demonstrations, video shows (Brown et al. 2002:168) and visits to real-world settings such as grocery stores (Brown et al. 2002:261; Mensing & Norris 2003:99).

Socio-cultural context

Attitudes and beliefs about foods tend to reflect cultural values. Cultural food practices not only affect taste preferences, but also shopping habits, manners, communication and personal interactions (Nestle et al. 1998:51). Family and friends provide a source of modelling and peer pressure for consuming particular foods or trying new foods (Nestle et al. 1998:51). Therefore, consideration of the socio-cultural context of the target group/patient is very crucial to increasing programme acceptance and effectiveness (Eakin et al. 2002:34).

Several studies have demonstrated that culturally sensitive interventions are effective in improving glycaemic control and dietary behaviours (Anderson-Loftin et al. 2002:245; Anderson-Loftin et al. 2005:560-562; Brown & Hanis 1999:25; Brown et al. 2002:259). Aspects that have been used in diabetes patient education to increase cultural relevance include using the patient’s preferred language, integrating cultural dietary preferences into healthy dietary strategies, integrating cultural traditions associated with food, such as family gatherings, incorporating family members (Anderson-Loftin et al. 2002:249; Brown et al. 2005:528), using ethnic food models to teach meal planning (Anderson-Loftin et al. 2002:249; Anderson-Loftin et al. 2005:557; Brown & Hanis 1999:231), using culturally familiar experiences such as drama (Rosal et al. 2005:227), and having open, non-judgmental discussions about health beliefs and practices (Brown et al. 2005:528).

Locality

Patients with low incomes and low educational attainment tend to have low education programme attendance rates (Corkery et al. 1997:257; Noel et al. 1998:896) and high attrition rates (Corkery et al. 1997:257). Patients with low incomes and low educational attainment tend to have low education programme attendance rates (Corkery et al. 1997:257; Noel et al. 1998:896) and high attrition rates (Corkery et al. 1997:257). Therefore, programme planners should incorporate aspects that enhance participation. A programme in a convenient locale that is easily accessible by public transport is crucial to solving the transport problem that is often cited as a barrier to participation in a programme (Eakin et al. 2002:27). Community settings such as schools, churches and community centres could be utilised as a strategy to overcome the socio-economic barriers to participation (Brown et al. 2002:168). These settings may be more convenient for and familiar to the participants (Brown et al. 2002:261) and their use is becoming more common, especially in under-served communities (Anderson-Loftin et al. 2002:528; Brown & Hanis 1999:230; Brown et al. 2002:168).

Appropriate nutrition education content and approach

The content of the NE should be based on assessed individual/group needs (Funnel et al. 2008:99). In newly diagnosed individuals, initial self-management education (survival skills) is necessary. This includes basic meal planning and exercise
Nutrition education for adults with diabetes mellitus in resource-poor settings

Provision of social support
Social support is an important element in dietary behaviour change (Adamson & Mathers 2004:541; Sherman et al. 2000:209). Social interactions can provide good models for healthy eating, and feedback that can reinforce or modify one’s self-evaluation. Peers, family and professionals can provide emotional support as well as challenge a patient’s stereotypes or negative expectations regarding the proposed change (Adamson & Mathers 2004:541; Nestle et al. 1998:51). Social persuasion helps to enhance confidence in individuals, and can assist diabetic individuals to improve their self-care behaviours (Lorig 2003:41). A study by Mau et al. (2001:1773) concluded that incorporation of social support (family member or friend) in an education program for individuals with diabetes or at risk of diabetes increased the likelihood of progressing from pre-action to action/maintenance stage for dietary fat intake and exercise. The study also concluded that individuals who advanced to action/maintenance stage had healthier dietary and exercise behaviours.

Suitable programme duration and contact time
There is very little guidance in the literature on the appropriate dosage (length and contact time) for diabetes education interventions. A few studies, however, do point to the fact that sufficient duration and contact time are necessary for a programme to be effective. A meta-analysis by Norris et al. (2002:25) showed that HbA1c levels decreased with increased contact time between the participant and the educator. Similarly, in a study of dosage effects of diabetes education for Mexican Americans, Brown et al. (2005:527) found that individuals who attended more sessions showed greater improvement in metabolic control. In another study, the same authors observed a maximum benefit effect of 15-19 contact hours and programme delivered over six months (Lorig 2003:4). This approach to meal planning could be useful in resource-poor settings, as it is simple, versatile and promotes understanding and memory retention (Camelon et al. 1998:98).

Provision of follow-up intervention
The maintenance of outcomes in individuals with diabetes is a challenge, and more so in minority groups and those with a low income (Eakin et al. 2002:32). In the meta-analysis by Norris et al. (2002:1159), the benefits of DSME were found to decline one to three months after the intervention. It therefore seems that follow-up intervention is necessary to maintain the achieved outcomes (Clement 1995:1208; Norris et al. 2001:563; Norris et al. 2002:1164). Additional group sessions at periodic intervals to reinforce previously learned self-management information and to provide social support are a feasible option in resource-poor settings (Brown et al. 2002:169).

Competent educator
An effective NE programme is a programme that is delivered by a competent educator (Mensing & Norris 2003:99; PADA 1996:1186). Characteristics of personal competency of successful nutrition educators include strong skills in interpersonal relationships, communication and listening, and interviewing skills (Knight et al. 2006:498; PADA 1996:1186), as well as skills in facilitating behaviour change (Fischer & Glasgow 2007:30; Mensing et al. 2007:97). In addition, the basic competencies of a dietetic/nutrition professional are also necessary. These include an understanding of the fundamentals of the food and nutrition sciences, knowledge of the physiological and psychological determinants of eating behaviour, and an understanding of the environmental and social implications of the food system (PADA 1996:118). A registered dietician is the professional who is recommended to conduct nutrition education for individuals with diabetes (Mensing et al. 2007:97; Wilson et al. 2003:2500). However, in resource-poor settings, this professional category is often not adequate or available. Therefore, other health professionals should be trained to offer nutritional education (IDE 2005:22-25). Trained peer educators could also be utilised to deliver the education (Mau et al. 2001:1171; Two-Feathers 2005:1552).

Table 1 summarises the elements that contribute to effective diabetes education, including MNT, derived from the reviewed studies. A conceptual framework of the factors that must be considered when planning an effective nutrition education programme for adults with diabetes mellitus in resource-poor settings is shown in Figure 2.

CONCLUSION
The results of this review indicate that effective nutrition education interventions for diabetic adults in resource-poor...
### TABLE 1
Summary of elements of effective nutrition education in adults with type 2 diabetes mellitus in resource-poor settings

<table>
<thead>
<tr>
<th>TYPE OF INTERVENTION</th>
<th>SAMPLE</th>
<th>SETTING/INTERVENTION</th>
<th>KEY OUTCOMES</th>
<th>EFFECTIVE ELEMENTS ($)</th>
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<td>Reach, implementation and maintenance</td>
<td>Convenient locality</td>
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<tr>
<td>Glazier et al., 2006</td>
<td>17 studies (1986-2004)</td>
<td>Low socio-economic status Minority groups Industrialized countries RCT DSME including MNT</td>
<td>Clinical outcomes</td>
<td>Tailored interventions</td>
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<td>Self-management</td>
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<td>Provider management</td>
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<td>Addresses socio-cultural context</td>
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<td>One-on-one education</td>
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<td>Randomised controlled trials (RCT)</td>
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<tr>
<td>Brown &amp; Hanis, 1999</td>
<td>n = 247 Mexican-American Low-income Low literacy</td>
<td>One-year intervention 12 weeks of group sessions</td>
<td>HbA1c, fasting blood glucose</td>
<td>Intensive intervention</td>
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<td>14 biweekly support sessions DSME including MNT</td>
<td>Diabetes knowledge</td>
<td>Cultural appropriate</td>
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<td>BMI, blood pressure</td>
<td>Community setting</td>
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<td>Total cholesterol</td>
<td>Needs assessment</td>
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<td>Minimal reading education materials</td>
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<td>Goldhaber-Fiebert et al., 2003</td>
<td>n = 75 Low-income Rural Costa Ricans</td>
<td>Community based Group nutrition and exercise programme 11 weekly nutrition classes (1.5 hours) Tri-weekly walking groups (1 hour)</td>
<td>HbA1c, fasting blood glucose</td>
<td>Community settings</td>
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<td>BMI, blood pressure</td>
<td>Offering classes at different time to improve attendance</td>
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<td>Triglycerides</td>
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<td>Rosal et al., 2005</td>
<td>n = 25 Low-income Spanish</td>
<td>Pilot study 10 weeks of group sessions</td>
<td>HbA1c, lipid profile</td>
<td>Tailored messages</td>
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<td>Two individual sessions Community centre DSME including MNT</td>
<td>Dietary intake</td>
<td>Intensive intervention</td>
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<td>Self-monitoring of glucose</td>
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<td>Using preferred language</td>
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<td>Use of visual materials</td>
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<td>Other study designs</td>
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<tr>
<td>Anderson-Loftin et al., 2002</td>
<td>n = 23 Rural African-Americans Low-income Low literacy</td>
<td>Quasi-experimental (longitudinal) Pilot study, five months MNT- 4 low-fat classes, 6 discussion groups Follow-up (One home visit + weekly telephone calls)</td>
<td>Fasting blood glucose, HbA1c</td>
<td>Experiential teaching methods</td>
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<td>BMI, blood pressure</td>
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<td>Total cholesterol, triglycerides, Home glucose monitoring</td>
<td>Culturally competent characteristics</td>
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<td>Dietary habits</td>
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<td>Health services utilisation</td>
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<td>Cost of care</td>
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<tr>
<td>Anderson-Loftin et al., 2005</td>
<td>n = 97 Rural African-Americans Low-income Low literacy</td>
<td>4 weeks MNT (low-fat dietary strategies) Five months of group discussions</td>
<td>BMI</td>
<td>Focusing on one dietary concept</td>
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<td>Weekly telephone follow-up</td>
<td>Dietary behaviours</td>
<td>Culturally competent characteristics</td>
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<td>Experiential teaching methods</td>
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<tr>
<td>Bannister et al., 2004</td>
<td>n = 70 Low-income</td>
<td>One group pre-test post-test Community clinic DSME including MNT 4-hour group class plus individual consultation by dietitian Monthly support meetings</td>
<td>HbA1c</td>
<td>Community site</td>
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<td>Costs</td>
<td>Family participation</td>
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<td>Brown et al., 2005</td>
<td>n = 216 Mexican-American Low income and literacy level</td>
<td>Comparison of dosage effects 52 contact hours vs. 26 hours Groups randomised, but no control DSME including MNT</td>
<td>HbA1c, fasting blood glucose</td>
<td>Attendance of more sessions with extended version</td>
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<td>Diabetes knowledge</td>
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<td>Diabetes-related health beliefs</td>
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<td>BMI, blood pressure</td>
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<td>Home glucose monitoring</td>
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<tr>
<td>Two-Feathers et al., 2005</td>
<td>n = 151 African-Americans Latinos Low SES</td>
<td>Community setting One group pre-test post-test One group pre-test post-test Delivered by trained community residents</td>
<td>Diabetes knowledge HbA1c</td>
<td>Community site</td>
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<td>BMI</td>
<td>Culturally tailored education materials</td>
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<td>Blood pressure, total cholesterol</td>
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<td>Home glucose monitoring</td>
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<td>Mau et al., 2001</td>
<td>n = 147 Rural Hawaiians</td>
<td>Community setting Quasi-experimental 6-month programme Addressing lifestyle behaviours Delivered by trained peers</td>
<td>Dietary behaviours (fat, fibre, calories)</td>
<td>Culturally tailored</td>
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<td>Physical activity</td>
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RCT – Randomised controlled trial  
BMI- Body mass index  
SES - Socio-economic status
settings are those that address their unique needs and abilities. Effective NE comprises certain key elements: these include addressing low literacy levels by use of visual materials; experiential teaching methods; repetition of key concepts; few dietary concepts at a time; and tailoring the education to the socio-cultural context. An intensive programme (> 10 contact hours and extended duration of ≥ six months), follow-up interventions and support from peers and family are also crucial elements. A convenient locality, such as a community setting, is also important for enhancing participation in NE programmes. Other elements that may not be unique to this population include the active participation of the learner, face-to-face delivery and the use of behaviour change techniques/theories.

Planners of NE programmes for individuals with diabetes in resource-poor settings must be sensitive to the unique needs of this population and plan interventions that address these needs. A comprehensive needs assessment will serve as a cornerstone for planning a tailored NE programme. The planners must also be clear on the goals and objectives of the programme, use appropriate implementation strategies/approaches, including a competent educator, and evaluate the programme for effectiveness at appropriate intervals.

This review has some limitations. The studies that met the inclusion criteria were few, and most of the studies were done in under-served low-income populations in the USA, thus it is not clear how these results relate to other resource-poor settings, particularly in developing countries. However, the results provide a base for planning NE education programmes for adults with type 2 diabetes in resource-poor settings.

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Nutrition education for adults with diabetes mellitus in resource-poor settings

Review Article


